



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Telemetry Unit Deficiencies VA New York Harbor Healthcare System New York, New York

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to determine the validity of an allegation regarding the quality of patient care on a telemetry unit at the Manhattan Campus of the New York Harbor Healthcare System, New York, NY. Specifically, the complainant alleged that a patient on the telemetry unit was not continuously monitored and the telemetry monitoring system displayed a disconnected telemetry lead. The complainant expressed concern that poor staffing and/or an equipment malfunction may have contributed to a lack of monitoring and the patient's death.

We could neither confirm nor refute the allegation that a patient on the telemetry unit was not continuously monitored due to a disconnected telemetry lead, malfunctioning monitoring equipment, or short staffing. The unit did not maintain sufficient documentation for us to determine if a telemetry lead became disconnected on the patient. We found that the telemetry equipment was functioning properly and that preventive maintenance was conducted in accordance with the manufacturer's specifications. Staffing on the night in question was consistent with the patient-to-nurse ratio that the system described as their usual practice based on industry standards.

However, our review did find that the unit had two system weaknesses that increased the risk of patients not being adequately monitored. Specifically, we found that medical record documentation by unit staff did not meet industry or facility requirements and that telemetry unit nursing and biomedical engineering staff were not trained to properly use the telemetry monitoring equipment.

To improve patient care and safety for telemetry patients, we recommended that the facility Director:

- Implement procedures to ensure that telemetry unit nursing staff comply with industry standards and system policies on charting and telemetry documentation to maintain a timely, complete, and accurate medical record for each patient.
- Ensure that telemetry unit nursing and biomedical engineering staff receive initial and refresher training on the telemetry monitoring system in accordance with Veterans Health Administration and facility policies.

The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA New York Harbor Healthcare System (630/00)

SUBJECT: Healthcare Inspection—Alleged Telemetry Unit Deficiencies, VA New York Harbor Healthcare System, New York, New York

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of an allegation made by a complainant concerning quality of care for a patient in a telemetry unit at the Manhattan Campus, New York Harbor Healthcare System (the facility), New York, NY.

Background

VA New York Harbor Healthcare System

The facility is part of Veterans Integrated Service Network (VISN) 3 and comprises three campuses located in Manhattan, Brooklyn, and Queens. The Manhattan Campus has bed services in acute medicine, surgery, acute psychiatry, neurology, and rehabilitation medicine. The campus is the VISN 3 referral center for interventional cardiology, cardiac surgery, and neurosurgery.

The telemetry unit (the unit) is a 19-bed step down unit located in the main hospital at the Manhattan Campus. Patients who are hemodynamically stable¹ but still require continuous electrocardiogram (ECG) monitoring are admitted to the unit, including patients who have been transferred from the medical intensive care unit (MICU) and the cardiac care unit (CCU).

Allegation

In April 2011, a complainant contacted the OIG's Hotline Division and alleged that in January 2011, a patient on the telemetry unit was not continuously monitored and that, according to a registered nurse (RN), the telemetry monitoring system displayed a disconnected telemetry lead. The complainant expressed concern that poor staffing

¹ Hemodynamically stable indicates that the circulatory system is functioning well enough to provide adequate blood flow throughout the body.

and/or an equipment malfunction may have contributed to a lack of monitoring and the patient's death.

Overview of Telemetry Monitoring for Cardiac Patients

Telemetry monitoring provides a continuous ECG reading of the heart's electrical activity through external electrodes placed on the patient's body. Segments of the ECG data are automatically transmitted to a remote surveillance location. As the patient's electrical rhythms are transmitted, they are continuously analyzed according to parameters programmed into the device. Some segments, such as rapid and slow heart rates or other symptomatic episodes, will automatically trigger an audible alarm. Hospital staff who acknowledge the alarms and observe the telemetry data are able to respond to the patient and provide immediate care should emergencies arise. The telemetry monitoring equipment at the system triggers three types of audible alarms:

- **Red Alarm** is an audible critical alarm that is loud and continuous. It indicates the need to immediately check on a patient's status and vital signs.
- **Yellow Alarm** is a quieter and intermittent audible alarm that stops after several minutes. It indicates a temporary irregularity in the heart rate or rhythm that is not immediately critical.
- **Blue Alarm** is similar to the yellow alarm and indicates a problem with the system itself or an improperly connected, or disconnected, telemetry lead.

Facility Policy and Industry Standards

According to the facility protocol for telemetry monitoring, all telemetry unit patients must be hemodynamically stable.² Unstable patients and those with Acute Coronary Syndrome³ should be managed in an intensive care unit. The protocol also identifies criteria for initiating telemetry monitoring on patients with various cardiac conditions. In this case, the patient required monitoring of his heart rate because of atrial fibrillation with rapid ventricular response⁴ but did not have chest pain.

According to the protocol, RNs on the unit are required to perform the following telemetry monitoring and documentation procedures:

² New York Harbor Healthcare System (NYHHS) Policy No. 111-05, *Electrocardiographic Telemetry Monitoring Protocol*, November 2008.

³ Acute Coronary Syndrome is when the heart does not receive enough oxygen-rich blood, which can cause chest pain or a heart attack.

⁴ Atrial fibrillation with rapid ventricular response is an irregular heart rate that can cause inadequate blood circulation through the heart, resulting in pooling of blood and eventual clots that can lead to stroke.

- Connect the patient to the telemetry monitor using a modified central lead-1⁵ or a lead that best transmits the appropriate waveform.
- Set alarm parameters according to the individual patient's needs and/or the physician's specifications, and ensure that the alarm volume is loud enough to be heard at all times.
- Keep alarms on at all times.
- Obtain and attach a representative sample of ECG strips to the hard copy medical record every shift and when necessary to document any abnormality and interventions instituted.
- Report any abnormalities to the physician.
- Review the alarms each hour.
- Respond immediately to alarm activation, institute appropriate intervention, and notify the physician.

Standards published by the American Heart Association (AHA) advocate that each facility establish protocols to govern the roles and responsibilities at all staff levels regarding cardiac monitoring, documentation of ECG changes, periodic documentation that alarms are set appropriately, and response to emergency and nonemergency cardiac events.⁶

The AHA recommends that all staff assigned to telemetry units receive comprehensive training, including initial orientation followed by periodic competency evaluations, to ensure continued proficiency in critical elements of cardiac monitoring. AHA also recommends periodic reviews of unit protocols, training curricula, and competency levels to determine if staff and patient needs continue to be met. This analysis should include reviews of staff performance, critical events, and patient outcomes.

Scope and Methodology

We conducted a site visit from June 14 through 16, 2011. To address the allegation, we interviewed the complainant, staff physicians, the unit supervisor and nursing personnel, and other clinical and administrative staff. We reviewed relevant facility policies and procedures, nurse training records, preventive maintenance reports, quality management documents, and the medical record of the patient identified in the complaint. We visited the unit, the MICU, and the CCU and reviewed the functions of the telemetry equipment with nursing staff and a member of the biomedical engineering staff.

⁵ A modified central lead-1 is the primary lead on a 3-lead telemetry monitoring system that is attached to the patient.

⁶ AHA Scientific Statement, *Practice Standards for Electrocardiographic Monitoring in Hospital Settings*, American Heart Association Science Advisory and Coordinating Committee, June 2004.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of Inspectors General on Integrity and Efficiency.

Case Summary

The patient was a man in his sixties with a history of 2-vessel coronary artery bypass graft surgery⁷ and mitral valve⁸ repair in 2007, high blood pressure, and atrial fibrillation. He presented to the emergency department in mid-January, 2011, with a chief complaint of shortness of breath on exertion for a duration of 2 weeks accompanied by weakness and fatigue. The emergency department admission assessment note indicated that the patient was oriented and denied any chest pain. His blood pressure was elevated, and the ECG showed the patient to be experiencing supraventricular tachycardia with a rapid ventricular response (endorsed as atrial flutter⁹ by a staff cardiologist's ECG report). The patient was treated with cardiac medications for ventricular rate control and transferred to the MICU for further management and monitoring.

The plan of care included monitoring of vital signs every 8 hours and heart rate and rhythm every hour. MICU nursing staff were to monitor vital signs and urine output, achieve full anticoagulation, continue outpatient medications, and institute cardiac monitoring (for ongoing assessment of heart rate control). Within 24 hours, (hospital day [HD] 2) the patient's heart rate was effectively rate controlled in the MICU. The MICU nursing progress note indicated no additional changes in the plan of care, and the patient was transferred at 7:30 p.m. to the CCU. Patients are transferred to the CCU, an area immediately adjacent to the MICU, when they still require close monitoring but at a less intense level than the MICU. A CCU physician's team note, written that same day, specified the plan of care was to schedule a cardiac ablation¹⁰ for the upcoming week in an attempt to more effectively control heart rate and to keep the patient in the hospital in the interim for ongoing anticoagulation, blood pressure control, monitoring, and observation.

On HD 3, the patient remained asymptomatic and was acceptably controlled as to heart rate. A resident physician ambulated the patient at 6:00 p.m., and, being clinically stable, the patient was transferred from the CCU to the telemetry unit, though he did have persisting significant blood pressure elevation.

The telemetry unit's nursing acceptance note documents the patient as arriving via wheelchair at 6:15 p.m. and being placed on a cardiac monitor showing him to be in

⁷ Coronary artery bypass graft surgery is a procedure to improve blood flow to heart tissue; it is most commonly performed by grafting a section of vein material to bypass an obstruction or narrowing of a coronary artery.

⁸ The mitral valve controls blood flow between the left upper and lower chambers of the heart.

⁹ Atrial flutter is a type of supraventricular tachycardia where the upper chambers of the heart beat abnormally fast and, when accompanied by a rapid ventricular response, the lower chambers also beat abnormally fast.

¹⁰ Cardiac ablation is a type of treatment for cardiac arrhythmias.

normal sinus rhythm¹¹ with occasional premature ventricular contractions,¹² a heart rate of 95 beats per minute, and persistent elevated blood pressure. The patient was also noted to be alert and oriented, having no chest pain, and ambulating independently. The plan of care was to include monitoring of vital signs every 8 hours and heart rate and rhythm every hour. A medicine resident physician's examination in the telemetry unit at 7:15 p.m. indicated the patient to be acceptably heart-rate controlled but with continuing high blood pressure readings ("uncontrolled at baseline"), and the physician's note expressed the intent to continue blood pressure control, anticoagulation, and plans for a "possible ablation" on HD 7.

At 7:30 p.m. on HD 3, the patient's nursing care was assumed by a new shift of nurses on the telemetry unit. The first chart entry made by the telemetry unit RN who had assumed responsibility for the patient at 7:30 p.m. was a transfer summary completed at 4:33 a.m. on HD 4, an hour after the patient was found unresponsive (that is, no nursing chart entries were made during the first 9 hours on this particular telemetry unit nursing shift).

The transfer summary included retrospective entries regarding the patient's condition from the previous evening. The note cited the patient as being on the telemetry monitor with normal sinus rhythm and a heart rate of 80 beats per minute as of 7:30 p.m. on HD 3. In addition, the note documented that the patient received his scheduled cardiac medication at 11:24 p.m. and had denied chest pain, dizziness, palpitations, or shortness of breath. The note chronicles that at 3:35 a.m. on HD 4, the patient was found unresponsive with no palpable pulse and with a blood pressure of 64/40 mmHg. At that time, staff initiated cardiopulmonary resuscitative measures and called a cardiac arrest response team to the unit.

Following resuscitative efforts, the patient was restored to a sinus bradycardia rhythm¹³ but with evidence of severe brain injury resulting from the cardiac arrest, as confirmed by a neurology resident physician. The patient was transferred back to the MICU at 4:45 a.m. on HD 4 and required ventilator support.

The period of unresponsiveness prior to the code is not determinable based on the limited nursing note documentation and the lack of telemetry data prior to the code. The patient's post-resuscitative severe brain injury, though, was associated with a poor prognosis and high mortality. According to an MICU nursing progress note, later on HD 4, the patient experienced a rapid drop in his blood pressure and heart rate, and a cardiac arrest response team was called at 2:15 p.m. Resuscitative efforts were unsuccessful, and the patient was pronounced dead at 2:35 p.m. on HD 4.

¹¹ Sinus rhythm is the normal beating of the heart as measured by an ECG.

¹² Premature ventricular contractions occur when the heartbeat is initiated by a site in the heart's lower chambers rather than its normal initiation site in the sinus node.

¹³ A sinus bradycardia rhythm is a regular but slow heart rate beating 60 beats a minute or less.

Inspection Results

We could neither confirm nor refute the allegation that in mid-January 2011, a patient on the telemetry unit was not continuously monitored due to a disconnected telemetry lead, malfunctioning monitoring equipment, or short staffing.

Disconnected Telemetry Lead. The telemetry unit did not maintain sufficient documentation for us to determine if a telemetry lead became disconnected on the patient. According to the patient's medical record, he was transferred from the CCU to the telemetry unit on HD 3 at 6:15 p.m. and placed on a telemetry monitor. A nursing transfer note written by an MICU RN at 4:45 a.m. on HD 4, after the patient was transferred back to the MICU, indicates that on HD 3, a telemetry RN checked on the patient at 7:30 p.m. According to the note, the patient was on the telemetry monitor at 7:31 p.m., which is supported by a unit report generated by the telemetry monitoring system.

We found no additional documentation in the patient's medical record, such as nurse progress notes or copies of telemetry monitor print-outs, or in unit monitoring records to verify if the patient continued to be on the telemetry monitor. We did find a telemetry observation record for HD 4, which indicated that nursing staff reviewed telemetry monitor alarms every hour. However, the telemetry observation record was not patient specific and did not reflect if any alarms had occurred. Furthermore, facility staff could not provide us this record for HD 3.

Malfunctioning Equipment. During our discussion with the complainant, the complainant referenced an ECG report in the patient's medical record indicating poor data quality, which may affect interpretation. The complainant expressed concern that this indicated some type of malfunction with the telemetry monitoring equipment. Based on our inspection of the equipment with a facility biomedical engineer and our review of applicable biomedical engineering records, we found that the equipment was functioning properly and that preventive maintenance was conducted in accordance with the manufacturer's specifications. We also found that an ECG was performed on the patient after the cardiac arrest on HD 4. Although the ECG report did indicate poor data quality, this is an indication that the equipment is functioning properly and informs the user that there is a presence of an artifactual signal, such as electrical interference from wall outlets, cell phones, muscle tremors, or patient movement.¹⁴ The presence of artifactual signal was not a significant finding in this case and did not, in any way, affect the patient's clinical outcome.

Short Staffing. According to facility nurse managers, the telemetry unit should have a patient-to-RN staffing ratio of 5:1. Although the facility does not have a policy explicitly requiring this staffing, the nurse managers told us that it is consistent with guidance from

¹⁴ Artifactual signal is anything on an ECG that is not caused by the electrical currents generated by the heart.

the American Nurses Association.¹⁵ On the night of January HD 3, there were nine patients on the telemetry unit, and staffing included two RNs from 7:30 p.m. to 8:00 a.m., a third RN from 12:00 a.m. to 8:00 a.m., and one nurse's aide from 3:30 p.m. to 12:00 a.m. Therefore, the patient-to-RN staffing ratio of 3:1 was well within the target ratio of 5:1.

Although we could neither confirm nor refute the allegation that the patient was not continuously monitored during his hospitalization in January, our review did find that the unit had two system weaknesses that increased the risk of patients not being adequately monitored. Specifically, we found that medical record documentation by unit staff did not meet The Joint Commission or facility requirements and that telemetry unit nursing and biomedical engineering staff were not trained to properly use the monitoring equipment.

Medical Record Documentation Did Not Meet Requirements

JC requires that a complete and accurate medical record be maintained for each patient.¹⁶ Facility policy requires an RN to print out an ECG strip every shift and to evaluate each alarm printout. The RN is also required to document any abnormal rhythms, provide a rapid response to each alarm, and review all alarms every hour.¹⁷

We found that patient care documentation lacked sufficient detail to verify whether patients were continuously monitored while on the unit. We found significant time gaps in nursing documentation in the subject patient's medical record. For example, the record contained a telemetry unit admission note for HD 3 at 6:15 p.m.; however, no further nursing notes were documented by a telemetry unit RN until 4:33 a.m. on HD 4, after the patient had been transferred back to the MICU. Furthermore, we did not find any ECG strips in the patient's medical record from the time he entered the unit on HD 3 at 7:30 p.m. to the time he was found unresponsive on HD 4 at 3:35 a.m.

According to telemetry unit staff, they also use unit-wide records to document patient observations and reviews of telemetry monitor alarms. Documentation of these records is for all patients on the unit and is not included in individual patient medical records. For example, we reviewed a unit report for HD 3, indicating that all patients on the unit were on telemetry monitors at 7:31 p.m. We also reviewed a telemetry observation record for HD 4, indicating that nursing staff reviewed telemetry monitor alarms every hour, as indicated by a check mark. However, as previously discussed, this telemetry observation record was not patient specific and did not reflect whether any alarms had occurred. Furthermore, we found that unit staff did not retain these unit records in a structured

¹⁵ Utilization Guide for the American Nurses Association *Principles for Nurse Staffing*, 2005.

¹⁶ Joint Commission, RC 01.01.01: The hospital maintains complete and accurate medical records for each individual patient.

¹⁷ NYHHS Policy No: 111-05.

format. As a result, unit staff were unable to provide us a telemetry observation record for HD 3, and records for most other days in January were also missing.

Staff Were Not Properly Trained on Monitoring Equipment

The AHA recommends that staff assigned to telemetry units receive initial and periodic refresher training on critical elements of cardiac monitoring. In addition, VHA policy requires that all personnel involved in the use of reusable medical equipment, such as telemetry monitors, have documented training on the setup, use, reprocessing, and maintenance of the equipment.¹⁸

During our interviews of the unit nursing staff, the unit nurse manager, and a biomedical engineer, we received inconsistent responses as to what type of alarm would be generated in the event that a telemetry lead became disconnected from a patient's chest. According to some staff, a "red alarm" would be triggered since a disconnected lead was considered critical; whereas other staff told us that a disconnected lead would trigger a yellow alarm or that it would not trigger any alarm at all. The staff were also inconsistent in their responses as to whether an ECG strip would automatically print if a lead became disconnected. However, all of the staff told us that an ECG strip would automatically print in the event of a red alarm.

We visited the unit to have the biomedical engineer and the nursing staff demonstrate the use of the monitoring system. During our observation of the system demonstration, several patients experienced yellow or red alarm incidents in realtime, yet no ECG strips automatically printed. We found that the alarm parameters to automatically generate ECG printouts were not properly set up on the monitoring system for any of the alarms. Furthermore, neither the unit nursing staff nor the biomedical engineer in attendance knew how to set the parameters on the monitoring system.

We also found that the unit nursing staff present did not know how to retrieve and print a patient's electronically saved telemetry history. The monitoring system automatically stores each patient's history for 24 hours and only purges it from the system once a telemetry box is cleared and connected to the next patient admitted. However, the history can be manually cleared once a patient is discharged. One physician we spoke to stated that an RN told him he would have to call the manufacturer's customer service and speak to a technician in order to retrieve a telemetry history.

Furthermore, we did not find evidence of competency training on the use of the telemetry monitoring system conducted by the manufacturer or any recent refresher training for the monitoring system in unit staff competency folders. For example, for one RN involved in the care of the subject patient, we found evidence of training that was last documented

¹⁸ VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

13 years ago; although, the RN's competency records indicated that this training should have been occurring annually.

Conclusion

We could neither confirm nor refute the allegation that a patient on the telemetry unit was not continuously monitored during his hospitalization in January, 2011, due to a disconnected telemetry lead, malfunctioning monitoring equipment, or short staffing. However, we did find that patient care documentation lacked sufficient detail to verify whether patients were, in fact, being continuously monitored while on the unit. In addition, we found that telemetry staff were not sufficiently trained in the use and understanding of the telemetry monitoring equipment to ensure that the correct patient parameters were set and that alarms sounded when necessary to alert staff to potential problems. Specifically, there was inconsistent knowledge among telemetry unit nursing staff as to the triggering events for various alarms, or even when an alarm would be triggered. As a result of these system weaknesses, patients on the telemetry unit are at increased risk of not being properly monitored.

Recommendations

Recommendation 1. We recommended that the facility Director implement procedures to ensure that telemetry unit nursing staff comply with The Joint Commission and facility policies on charting and telemetry documentation to maintain a timely, complete, and accurate medical record for each patient.

Recommendation 2. We recommended that the facility Director ensure that telemetry unit nursing and biomedical engineering staff receive initial and refresher training on the telemetry monitoring system in accordance with VHA and facility policies.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 2, 2011

From: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

Subj: **Healthcare Inspection—Alleged Telemetry Unit Deficiencies, VA New York Harbor Healthcare System, New York, NY**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Thru: Director, Management Review Service (10A4A4)

Attached please find the response to the draft alleged telemetry unit deficiencies report for VA New York Harbor Healthcare System (VANYHHS).

The VISN concurs with the action plan submitted by the facility.



Michael A. Sabo, FACHE

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 2, 2011

From: Director, VA New York Harbor Healthcare System (630/00)

Subject: **Healthcare Inspection—Alleged Telemetry Unit Deficiencies, VA New York Harbor Healthcare System, New York, NY**

To: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

This is to acknowledge receipt and review of the draft alleged telemetry unit deficiencies report for VA New York Harbor Healthcare System (VANYHHS). Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please contact Kim Arslanian, the Performance Improvement Manager at (718-630-2865).



MARTINA A. PARAUDA

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the facility Director implement procedures to ensure that telemetry unit nursing staff comply with JC and facility policies on charting and telemetry documentation to maintain a timely, complete, and accurate medical record for each patient.

Concur

Target Completion Date: 6/15/11

Facility's Response:

Effective 6/15/11, the Associate Director, Patient Services (Chief Nurse) issued an e-mail to the appropriate Nursing management staff mandating compliance with the documentation requirements as per the current policy.

In addition, a workgroup that includes the Associate Director, Patient Services, Associate Director Facilities and Human Resources and the Performance Improvement Manager has been meeting since July to review current telemetry practices and have modified the policy as per the suggestions made during the OIG site visit. The revised documentation will be scanned into CPRS. The final draft policy has been forwarded to the Clinical Executive Board (CEB) for review and approval. Once approved by the CEB the policy will be reviewed by the Executive Council (EC) for approval. Once approved, the revised policy will include a system for monitoring compliance and a medical record review to monitor documentation. The EC is scheduled to meet on Oct 26th.

Status: Policy approval pending CEB and EC approval.

Recommendation 2. We recommended that the facility Director ensure that telemetry unit nursing and biomedical engineering staff receive initial and refresher training on the telemetry monitoring system in accordance with VHA and facility policies.

Concur

Target Completion Date: 9/6/11

Facility's Response:

The manufacturer provided training for all appropriate staff on several days (July 12, 13, 14, 28, August 1, 2, and September 6). 98% of staff were trained. Remaining 2% reflect those staff on extended leave.

In addition, Nursing Education has developed a curriculum for training new and current employees. The plan will be added to TMS for tracking and assigned to all appropriate employees. Initial and annual competency assessment checklists were reviewed as well.

Status: Complete

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Claire McDonald, MPA, Project Leader Glen Pickens, RN, MHSM, Team Leader Thomas Jamieson, MD Frank Keslof, EMT, MHA

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